UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

AMITIZA (lubiprostone)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

---

FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of Chronic Idiopathic Constipation
- Documented failure within the last 12 months using;
  - A. One fiber laxative **AND**
  - B. Two stimulent laxative products
- Drug induced constipation must be ruled out

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

To request authorization after 6 months, the patient will need to show trial off Amitiza using other laxatives for at least 30 days. **NO FURTHER AUTHORIZATION WILL BE GIVEN AFTER THE PATIENT HAS A TOTAL OF 1 YEAR OF THERAPY WITH AMITIZA.**

7/7/6